RIDEOUT
MEMORIAL HOSPITAL

October 14, 1997

Health Policy and Planning Division
Office of Statewide Health Planning and Development
1600 9th Street, Room 350
Sacramento, CA 95814

Dear Sirs:

We have reviewed the draft of the 1997 Report of the California Hospitals Outcomes Project and would like to see the following comments published with the report.

One of the stated goals of the Outcomes Project, is to provide the public with information that objectively compares hospitals according to the quality of their care. We are concerned that data used for this study, which will not be made public until late in 1997, encompasses hospital discharge data from 1991-1993! Although we appreciate the difficulties of completing such a comprehensive study using more timely data, we have great concerns that the public will interpret this data as representing the current state of quality care within the facilities. *It is imperative that this be clearly stated in the limitations of the study.* Over the last several years, hospitals have moved from quality assurance to continuous quality improvement; data is assessed on a continual basis and strategies implemented and modified continuously to improve processes and outcomes. Any report focusing on outcomes of patients who were discharged 4 years ago does not take into account the improved patient outcomes, which have been achieved through quality improvement efforts.

We are also concerned that the implication of this study to the lay public may be that patient outcomes, such as mortality, are solely due to the interventions initiated by the medical personnel treating the patient, when in fact the patient's own health maintenance and willingness to comply with the treatment regime are also key to long term survival! Patients who are noncompliant with the recommended treatment plan post discharge, may experience higher 30 day mortality. This is then attributed back to the index hospitalization, yet this has nothing whatsoever to do with the quality of care provided during the initial hospitalization for acute MI. As for the risk adjustment methodology, we feel that Model A is of limited value, since it includes only those clinical risk factors likely to be present on admission; Model B more realistically factors in comorbidities that will significantly impact the outcome of the AMI patient. Neither model, however, identifies other important factors that have the potential to significantly increase mortality. These include, but may not be limited to: 1) delays in patient presentation which result in significant loss of myocardium prior to arrival at the hospital, 2) contraindications to thrombolytic therapy which limit the effective interventions available to reduce morbidity and mortality and 3) patients who refuse aggressive intervention to limit infarct size.

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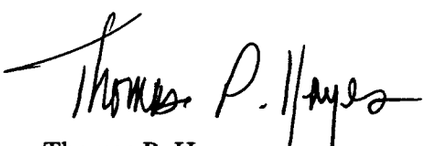
In addition, we have concerns that by "linking serial hospitalizations that comprise a single episode of care," mortality rate can be adversely affected when a patient is transferred for interventional therapy that is not available at the referring facility (such as coronary artery bypass graft surgery or percutaneous transluminal angioplasty which each carry additional risks). Rideout Memorial Hospital performs diagnostic cardiac catheterizations only, but must refer all patients requiring CABG or PCTA to Sacramento area hospitals. According to the design of this study, mortalities occurring in those facilities as a complication of interventional therapy would adversely affect mortality data for Rideout Memorial Hospital! Also, it is not completely clear whether deaths due to unrelated causes, occurring within 30 days of an initial hospitalization for an AMI, would factor into the overall mortality rate for AMI's. Certainly, a death attributed to a pre-existing condition, such as cancer or chronic obstructive pulmonary disease, should be excluded from the mortality data for AMI.

Care of the MI patient with specific emphasis on patients receiving thrombolytic therapy has been one of many quality improvement efforts in place at Rideout Memorial Hospital since 1989, well before the initial data from the Outcomes Project was published. In 1993, our facilities joined the National Registry for Myocardial Infarction (NRMI). This has allowed us to compare hospital-specific data to the cumulative data for both California and the Nation. A multi-disciplinary group consisting of physicians, ER and ICU nursing staff, and representatives from Pharmacy and Cardiology continues to meet at least quarterly. Our quality improvement efforts have been successful and we can demonstrate improved time to treatment and reduced in-hospital mortality rates. While our results are reflected as "not significantly different than expected", we are confident that our current mortality rate for AMI patients is at or below the threshold established by the Outcomes Project. All mortalities are reviewed and deaths of MI patients have been evaluated on a case by case basis by the MI task force. The MI task force continues to seek strategies to improve the outcome for patients experiencing acute myocardial infarction and is currently focusing on concomitant medication therapy, recognizing its importance in survival rates post MI.

The data from the OSHPD California Hospitals Outcome Project is only one of many reports that we utilize to assist us in our performance improvement efforts. Despite the concerns listed above, we do take this data seriously and have shared the information with the Director of Quality and Risk Management, Director of Medical Quality Improvement, the Critical Care Nurse Manager, the physician chair of the Acute MI task force and the appropriate medical staff departments for the purpose of continuing to improve the outcomes for our patients.

Thank you for the opportunity to review the draft of the Outcomes Project and to respond with comments to be printed in the final published report.

Sincerely,



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